CITY OF MESA
Great People, Quality Service!

INSURANCE CLAIM APPEAL FORM

Insured Information

Insured Name			
Insured Home Address			
City		State	Zip
Insured SSN	Work Phone	Work Phone	

Provider of Service

Attending Physician
Physician Address (Street, City, State, & Zip)
Physician Phone Number

Claim Information

Claim Number	Diagnosis
Type of Claim: Medical ☐ Dental ☐	Nature of Treatment (including Surgery & Medication)
Date of Treatment	

State in clear concise terms the reason or reasons for your disagreement with the way the claim was processed:

Note: Attach a copy of denial explanation of benefits and all other information (including Doctors notes) you wish to have considered.

This request must be made within 60 days after the claim was processed.

- **Upon receipt of this completed form, the Employee Benefits office will review you claim to determine whether or not it was properly processed according to the Plan Document.**
- **If after review by the Benefits Office, you are still not satisfied, you may request further review by the Employee Benefits Advisory Committee. The request must again be made in writing and must be received within 30 days of the date you were notified by benefits.**
- **The Employee Benefits Committee at its next scheduled meeting will then review the claim. You will be invited to appear before the Advisory Committee to state your position. The Advisory committee will review the documentation and information presented to them and render a decision. This decision will be communicated to and will be considered final.**

Signature of the Insured	Date